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ABSTRACT

Cultural competence is a set of behaviors, attitudes, and policies that enable a system, agency, or individual to function effectively in trans-cultural interactions. The term refers to a person or program's ability to honor and respect the cultural differences of individuals and families who are clients and staff. A culturally competent system recognizes that: (1) families are the primary support system; (2) individuals and families make different choices based on cultural forces; and (3) cultural minorities must be at least bicultural to survive in society. Designed and compiled by the Community and Family Health Division (CFH) of the Washington State Department of Health, this guide serves as a "blueprint" for other agencies to adapt to multicultural needs. The guide reflects the actions of CFH to build cultural competence within its own system. Chapters in the guide are: (1) "Architects," describing the Multicultural Work Group's origins, functions, and responsibilities; (2) "Breaking Ground," describing workshops conducted by the Multicultural Work Group, including training goals and workshop development; (3) "Tools," describing training sessions and activities that meet the need for ongoing learning of CFH staff; (4) "Foundation," focusing on systemic changes at the state and national level; and (5) "Structure," outlining a strategic plan for cultural competence. Five appendices include definitions and the mission statement of the Multicultural Work Group. Contains 15 references. (BGC)

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BUILDING CULTURAL COMPETENCE

A BLUEPRINT FOR ACTION

SEPTEMBER 1995

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The National Maternal & Child Health Resource Center on Cultural Competency

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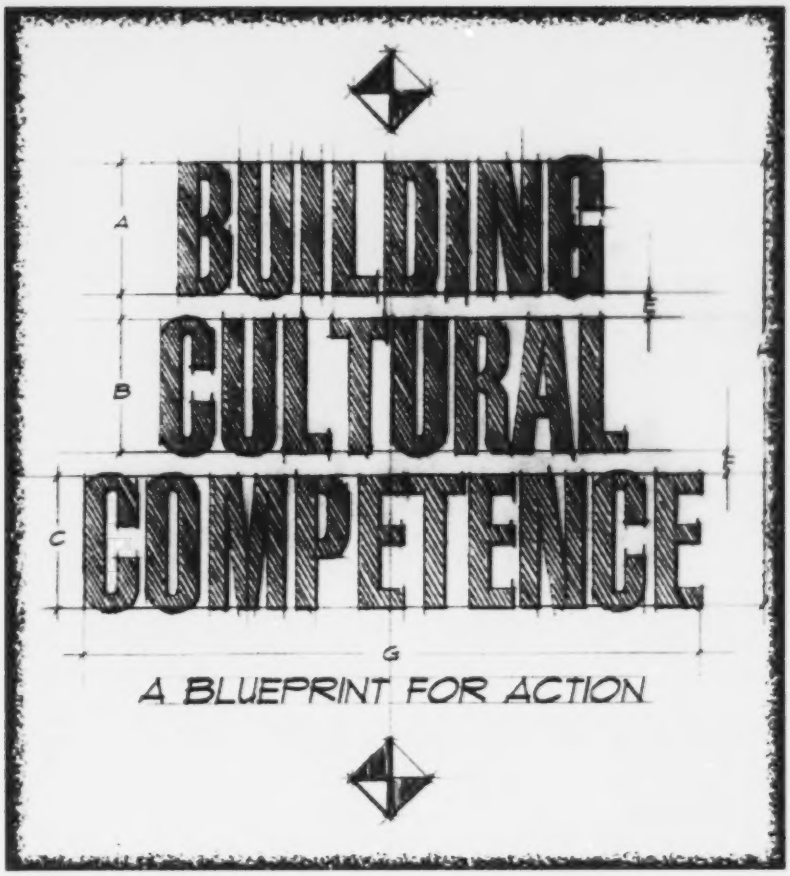
The foundation of cultural competency is accepting differences, and committing to communication and effective action regardless of differences.

National Institute of Mental Health
Child and Adolescent Service System Program



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September 1995

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

Dear Colleague:

Demographics are dramatically changing in our country and in the Pacific Northwest. Instead of one melting pot, we have a platter with many dishes! In Washington State, for example, the diversity of cultures that has always existed has been augmented by the tremendous influx of different ethnic groups. Complicating these population changes is the fact that many individuals within these groups are poor and are disenfranchised by mainstream society. They are faced with many non-financial barriers that impede their access to health services.

The Healthy People 2000 National Health Promotion and Disease Prevention Objectives emphasize cultural competence as an integral component in the delivery of health and nutrition services. WIC, Title X, and Title V in particular through the OBRA '89 amendments, encourage state health agencies to assure the provision of culturally competent services to women and children, including children with special health needs.

In 1991, the MCH program within Community and Family Health of the Washington State Department of Health provided leadership in integrating cultural competence at the systems level. The focus of this report is to provide specific examples of effective state strategies in addressing the needs of diverse, growing populations, as well as challenges that any state would face in this process. This report contains examples of processes uses to operationalize complex concepts that are meaningful to staff and to programs.

While we are pleased that the National MCH Resource Center on Cultural Competency focused on Washington State as a case study, and are certain that the blueprint outlined in this report will be helpful to state health agencies and particularly MCH programs, we are acutely aware of the many challenges ahead. Quality assurance issues and evaluation of the impacts of our efforts are still being developed. As the health system of Washington State changes, influencing new and old providers of care on the importance and value of culturally competent systems and holding them accountable takes on new meaning. The division of Community and Family Health will continue to provide leadership and look for those new opportunities to extend its work in this important arena.

Maxine Hayes, MD, MPH
Assistant Secretary
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Foreword

By the National Maternal and Child Health
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The progress towards implementing cultural competency principles at an agency level is documented in these efforts by the Community and Family Health staff of the Washington State Department of Health. It is evident that enlightened and dedicated leadership is being provided by Assistant Secretary Maxine Hayes, M.D. What is even more apparent in these efforts is the staff's discovery and valuation of other C's—concepts—in cultural competence, i.e., family-centered, community-based, comprehensive, coordinated.

As the Multicultural Work Group initiated its activities with the staff, the effect and impact of these other C's became the real determinants of progress along the cultural competency continuum. Specifically, it became obvious to them that:

> The *challenge* to their *cultural convictions* required a *courageous* personal *commitment* to *conscientious* and *constant change* over time as a result of *communicating* and *comprehending common characteristics* in the human *community* while learning to *cope confidently* with *complex* differences and diversities.

It is our hope that these experiences will not only provide an impetus for decision and policy makers, but will also become a framework and reference for implementing cultural competency in other health and human service agencies.

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Building Cultural Competence

A BLUEPRINT FOR ACTION

Executive Summary

The Washington State Department of Health (DOH) has a commitment to assure that all state residents receive culturally competent[1] public health services. While the need for cultural competence has always existed, an increase in the state's diversity has brought this issue to the forefront. Given the changing population and state and federal mandates, the Community and Family Health Division (CFH) began exploring cultural competence issues in 1991. The National Maternal and Child Health Resource Center on Cultural Competency publishes this story of CFH's process to guide other agencies in their efforts toward competence.

Because competence must be "custom-built," other agencies will adapt this blueprint to suit their specific needs. This blueprint reflects the actions of CFH to build cultural competence within its system, and includes:

- *I. Architects: Multicultural Work Group* describes the composition, functions and responsibilities of the CFH work group in creating the blueprint for action.
- *II. Breaking Ground: Awakening Awareness* shows how the work group initiates a formalized cultural awareness and training process.
- *III. Tools: Awareness, Knowledge, Skills, Encounters* describes the opportunities the work group offers for acquiring the tools of competence.
- *IV. Foundation: Systemic Changes* reports changes in the federal, state, DOH and CFH systems that are forming the foundation for competence.
- *V. Structure: The Working Plan* explains work now underway and work to come. CFH will remodel the plan to meet changing needs.
- *VI. References* includes many of the resources the work group found useful.
- *VII. Appendices* includes relevant definitions, illustrations, guidelines and forms.

Acquiring cultural competence is an ongoing, developmental process. Individuals and groups need time to absorb their learning and put it into action. Acquiring competence within an organization requires the commitment and participation of all levels, administration through front-line staff. It means interacting competently within the organization, as well as externally. To provide culturally competent services, agency staff must first interact competently with one another.

In a grass-roots effort over four years ago, informal staff groups began to explore the concept of cultural competence. Since that time, CFH has reached several milestones:

- CFH management formalized the Multicultural Work Group to lead the effort toward building competence.
- All staff participated in the Cultural Awareness Training and Assessment workshop.
- All staff participated in developing—and reached consensus on—cultural competence goals.
- Training on specific cultural competence skills and issues occurs regularly.
- Work group members serve as a resource for DOH, for contractors and other community-based health providers, and for other states, universities and organizations on issues of cultural competence.
- Systemic changes range from increasing community involvement in funding and contracts to recruiting culturally diverse staff, and from delivering services with competence to assuring comprehensive health data collection for minority and ethnic populations.

[1] *Appendix 1: Cultural Competence Definitions*

Simultaneously, DOH is making systemic changes toward achieving cultural competence with the involvement of Multicultural Work Group members:

- DOH reinstated the Office of Minority Affairs to promote cultural competence internally and externally, and to assure that services are accessible and responsive to the needs of culturally diverse communities across the state.
- The Secretary created the Secretary's Diversity Work Group to challenge staff to change the culture of the agency to value diversity, and to institutionalize diversity in the department agenda.
- DOH is making great strides in "partnering" with communities, particularly through the development of the *Public Health Improvement Plan* that charts the future of public health in Washington communities. The plan creates statewide public health standards that take into account diversity and competence issues.

Much work remains. The CFH Multicultural Work Group is now creating a strategic plan to implement the cultural competence goals. They will market the plan to CFH management and staff, and DOH administration. Implementing the plan will be a long-term process. In the meantime, the milestones achieved continue to produce positive results.

This report shares CFH's experiences in the challenging process of building cultural competence. It discusses participants, barriers, activities, changes and the ongoing effort. Many CFH staff members see increasing competence as a rewarding aspect of personal growth. For CFH as an organization, cultural competence holds the promise of a more trusting, comfortable and productive internal environment, and more effective client services.

1. ARCHITECTS

Multicultural Work Group

The work group develops the concept of cultural competence into a blueprint for action.

The Multicultural Work Group is the linchpin of the Washington State Department of Health (DOH) Division of Community and Family Health (CFH) commitment to building cultural competence. The activities of the work group are the basis of ***Building Cultural Competence: A Blueprint for Action.***

The work group evolves

Today, the formal Multicultural Work Group consists of one designated representative from each CFH office and a member of the CFH management team. Its predecessors were two independent grass-roots staff groups. Both groups formed voluntarily, inspired by Dr. Maxine Hayes, DOH Assistant Secretary and a member of the National Maternal and Child Health Cultural Competency Work Group for Children with Special Health Care Needs. When the national group obtained a grant to create the National Maternal and Child Health Resource Center on Cultural Competency, they selected CFH as a demonstration site and Dr. Hayes formalized the work group.

An internal reorganization in DOH posed a challenge to the efforts underway to build cultural competence. DOH merged two separate divisions—essentially, two different cultures—as CFH. Both divisions had the grass-roots work groups dedicated to achieving cultural competence. As merging the divisions challenged the cultural competence of all staff, merging the two work groups challenged the cultural competence of both groups' members.

After considerable effort, the re-formed work group approved a mission statement (*Appendix 2*). Periodically, the group revisits the mission statement to reflect the dynamics of change within CFH and its staff.

Functions and responsibilities

The work group leads CFH in building competence, and serves as a resource for other organizations. Members are instrumental in assuring that CFH program goals, objectives and work plans achieve the DOH vision in a culturally competent manner. They keep staff continually informed of work group activities, and communicate staff ideas to the work group. Work group activities are not "extra"; they are part of each member's overall work assignment.

The work group found that to lead an organization in building competence requires the following functions:

- **Assessment.** Examining staff and organization attitudes and beliefs about cultural differences, and about the cultural competence of organization policies and services.
- **Policy development.** Defining terms, goals and objectives; obtaining financial commitments from administration; creating an understanding among staff of culture, and of cultural diversity, sensitivity, relativity and competence, and of the need for becoming competent; developing written policies, standards and guidelines concerning cultural competence. (While CFH did not use a consult-

ant for this process, the work group suggests that a consultant may facilitate the focus on agency needs.)

- **Assurance.** Compiling results of the assessment, and making recommendations for ongoing activities toward becoming a culturally competent agency.
- **Training.** Ongoing instruction to increase cultural awareness, knowledge, skills and encounters; and training staff to conduct awareness and assessment workshops with new staff, local health departments and contract agencies.
- **Outcomes.** Conducting both pre- and post-studies and surveys of cultural competence to assure that the outcomes achieved are the outcomes desired. (CFH did not have the resources for measuring outcomes in the early years; the work group recommends including this function.)

Overcoming barriers to success

In its efforts to lead an organization toward cultural competence, the work group identified three principal roadblocks and the strategies to overcome them: (1) resistance to change; (2) available time, available staff; and (3) funding.

- **Resistance to change.** This applies to both staff and management. Sometimes organizations may agree with the change, but will not commit the time and money required to effect the change.
  Strategy: Knowledge ultimately breaks down resistance. At every opportunity, restate that cultural competence is essential for meeting the organization's goals of good health outcomes.
- **Available time, available staff.** If work group members must fulfill all their usual work responsibilities and also be a change agent in the organization, their conflicts in time and commitment will slow the development of cultural competence. Especially at the outset, work group activities are time-consuming: monthly meetings, regular sub-group meetings, and periodic individual assignments that could take three or four work days. Initially, the work group chair spent 20 percent of her time on cultural competence issues, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) cultural competence specialist 35 percent of her time.
  Strategy: All work group members must have cultural competence activities built into their job classifications. When cultural competence becomes systemic, it is a natural part of all job classifications, job performance and project success.
- **Funding.** When funds are short, the day-to-day agency activities may take precedence over the process of becoming culturally competent.
  Strategy: A culturally competent organization is also a well-organized, well-run organization that uses existing funds effectively to assure equitable and appropriate services to all clients. An organization aiming for healthy outcomes for all clients does not allocate its limited funds to programs that do not meet the needs of all groups. Funds allocated for culturally competent programs receive top priority.

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A preliminary assessment

Initially, the work group's tasks were largely exploratory. How culturally competent were the services in place? Community health organizations, tribal and migrant health programs, and local health jurisdictions were and are urging DOH to address the specific needs of increasingly diverse clients. Many issues relate to the system's long-term disparities in meeting the health care needs of culturally diverse people. Other issues concern the significant increase over the last decade in the ethnic and cultural diversity of residents.

To increase their own understanding and establish a springboard for work, the work group researched definitions related to cultural competence. They chose to adopt those developed by the Maternal and Child Health National Resource Center on Cultural Competency *(Appendix 1)*.

The work group surveyed CFH staff concerning the strengths and weaknesses of their programs in meeting needs of diverse populations in a culturally competent manner *(Appendix 3)*.

Setting and prioritizing goals

Based upon their research, the work group established goals to:

- Increase staff awareness and understanding of cultural issues.
- Define what it means for CFH to be culturally competent.
- Increase cultural diversity internally.
- Assure that all planning activities, policies, program development and funding decisions result in culturally appropriate, accessible services to Washington's communities and families.

The work group chose to focus first on increasing staff awareness and understanding of cultural issues. The next chapter describes what they did to achieve that goal.

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II.

BREAKING GROUND

Awakening Awareness

The work group broke ground by increasing staff awareness and understanding of cultural issues.

The Multicultural Work Group identified cultural awareness training and assessment as the first step toward building increased cultural competence within CFH and with clients. Cultural awareness training and assessment are a form of "consciousness-raising." They help persons identify their attitudes, beliefs and values about race, gender, age, ethnicity, religion, sexual orientation and disabling conditions that inform their behavior toward co-workers and clients.

Through research, the work group found that organizations and individuals require different assessment models. Organizational assessment usually involves a survey questionnaire of all staff (from policymakers to service providers), along with in-depth interviews of key personnel. Individual assessment can involve a questionnaire, or experiential exercises that enable individuals to look at their attitudes, beliefs, biases, prejudices, etc. Having set and prioritized goals for CFH, and researched assessment and training, the work group determined that a combination of the assessment models would be most effective.

Expectations for the workshop

The Multicultural Work Group expected the workshops to awaken the cultural awareness of staff and the organization. A related, expected outcome was that staff would make changes to enhance their cultural competence with one another and in service delivery. The work group did not see "deep-seated personal change" as a function or a responsibility of itself or the organization.

The Multicultural Work Group identified the following goals for the training:

- Explore and understand the idea of culture.
- Promote awareness of diversity within the agency.
- Identify agency culture including internal and external relationships.
- Identify agency needs.
- Identify skills for cross-cultural communication.
- Train work group members to be facilitators for future trainings.

The work group concluded that conducting this type of training may be difficult and inappropriate for in-house facilitators. Examining one's beliefs, biases and prejudices can prove provocative and challenging. To be successful, the training requires a "safe" environment in which everyone can openly state feelings and opinions, disagree, and be assured that information shared is confidential. The work group recommended holding the workshop off DOH premises, and enlisting experienced facilitators from outside the organization.

Selecting facilitators

Contracting with an outside consultant required weeks of preparation by Multicultural Work Group members. After obtaining approval, they sought funding. They received some funds from the National Maternal and Child Health Resource Center on Cultural Competency; and the

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remaining funds came from sources determined by DOH administration.

Work group members developed a Request for Proposals (RFPs), located potential candidates, sent out RFPs, evaluated proposals and selected candidates to interview. They interviewed candidates concerning their approach to cultural competence, training style and experience, and their "fit" with CFH values, goals and objectives. They selected the consultant who best met their needs, and developed a contractual agreement between the consultant and CFH. For details on conducting this process, see *Appendix 4*.

Developing content

The work group and the consultant communicated through meetings and teleconferencing to develop the workshop content. They agreed on a combination of cultural awareness training, and processes for both self-assessment and organization assessment. They chose an interactive format with a variety of experiences to enable each person to evaluate himself or herself and the organization.

Through the workshop exercises, participants examined their own hopes and fears, interacted with others of different "cultural" interests, and actually "created a culture" within a small group. The "cultures" then interacted with each other, discussing their communication obstacles, strategies and feelings.

At three points during the process, the consultant asked participants, individually or in small groups, to record their responses to the following three issues, respectively:

Perceptions. These questions examine CFH's culture and perceptions:

- How do unit staff tend to perceive clients and other people outside the agency?
- How do we perceive ourselves as a unit?
- How might our clients and others outside our unit perceive us?

Reflections. This two-part question begins a dialogue on assessing where the agency stands on cultural competence:

- What is cultural competence? What are the agency's strengths and weaknesses?

Where To? This question is an opportunity to recommend a direction for the future:

- Where do we go from here?

At the conclusion of the workshop, the consultant asked all participants to complete a Cultural Awareness Training and Assessment evaluation form.

Workshop insights

The consultants analyzed the responses to the questions and met with the work group to share observations. Together they created a list of strengths, and a list of areas for improvement. In sum, they drew the following conclusions about the trainings:

- It is difficult for staff to invest time and energy into an effort that the agency may not sustain and support. A long range plan is essential for staff to be certain of the agency's long range commitment.
- Staff backgrounds in diversity and cultural awareness range from low to high levels of awareness and competence. This wide range requires a variety of approaches to raise the organization's level of cultural competence. CFH must continually offer activities that promote awareness, and that span a range of depth and intensity.
- While CFH staff were generally receptive to the workshops, it is critical that all staff feel that they can express their opinions without criticism or repercussions. Generally, staff were eager to talk with each other during team building and communication exercises, both within and across units.
- The leadership of the work group promotes respect for diversity and for acquiring competence. The addition of new members strengthens the work group. The work group must continue to communicate with the entire staff, and welcome new members to participate at whatever level they can commit.

The importance of ownership

In hindsight, the workshops received strong support from all levels of CFH because they gave everyone "ownership" in building cultural competence. All staff had the opportunity to participate in developing the cultural competence goals that will be the basis of the strategic implementation plan.

As a result of staff feedback on the workshops and the consultant's recommendations, the work group was able to formulate the next steps toward building competence.

III.

Awareness, Knowledge, Skills, Encounters

The work group provides ongoing opportunities for acquiring the tools of competence.

The Multicultural Work Group continues to create new trainings and activities that meet the need for ongoing learning, and the increased sophistication of CFH staff.

Increasing awareness

The Multicultural Work Group organizes brown bag lunch discussions to create an ongoing awareness among staff members of the importance of culturally competent services. Attendance is voluntary. The programs stimulate interest and draw respectably sized groups. Examples of topics include:

"True Colors." In this documentary by ABC's "Prime Time," a hidden camera films a white and a black male as they apply for a job, try to rent an apartment, and buy a car.

Sexual Orientation and Civil Rights. Nancy Reid, Thurston County Hands Off Washington. What kind of anti-gay and lesbian legislation can we expect to see this legislative session? Hands Off Washington's goal is to defeat threats to civil rights based on sexual orientation.

Our Newest Residents: Their Cultures, Strengths, and Social and Health Issues. Mykhanh Nguyen, Refugee and Immigrant Service Center, Olympia. The immigrant and refugee populations in Washington State are changing. What cultures and strengths do our new residents bring with them, and what particular health and social issues do they face?

What is Environmental Racism? Frank Westrum, Environmental Epidemiologist, Washington State Department of Health. Most of Washington State's 54 Superfund hazardous waste sites are located in low income, minority communities. Is this racism or a function of normal economic pressures?

Adding knowledge and skills

The Multicultural Work Group creates opportunities for CFH staff to learn cultural knowledge and skills. By acquiring cultural knowledge, individuals can understand the world views of other cultures, including their conceptual and theoretical frameworks. By acquiring cultural skills, individuals can assess a client's mode of interacting with the outside world, and reach out to the client to provide culturally relevant services.

Training at all-staff meetings. The work group offers presentations at CFH staff meetings to increase awareness, knowledge and skills. Feedback indicates the presentations are thought-provoking and useful. Examples of topics include: African-American Women's Health Issues, Developing Culturally Competent Materials, and The White Culture.

In-service training modules. In response to the feedback from the training and assessment workshops, the work group developed a series of two-hour workshops that combine theory and experiential exercises to expand individual and agency awareness, knowledge and skills. The voluntary workshops, described below, do not require advance registration:

- ***The Concept of Culture.*** Understanding what culture is. How we each view change. Our

personal value system. Value conflicts and how to resolve them.

• ***Cultural Awareness.*** What does it mean to be culturally aware? Multicultural issues in the workplace. Path to intercultural learning. Discussion of racism, bias, stereotypes.

• ***Cultural Assessments.*** Cultural assessments and how to conduct them. Individual and organizational assessments.

• ***Cross Cultural Communication Part I: Interpersonal Communication.*** Sharing interpersonal communication styles and recognizing generalities, stereotypes and prejudices through experiential exercises. Practicing skills in responding to potential work scenarios.

• ***Cross Cultural Communication Part II: The Health Care Setting.*** Building skills for consulting with direct service providers who work with diverse communities. Exploring how culture affects health beliefs.

Technical assistance and consultation. In working with the consultant on the training and assessment workshops, Multicultural Work Group members learned skills for providing technical assistance and consultation. These members help many groups involved in assuring culturally competent services—from policymakers and management to front line staff and consumers. Assistance includes: focus groups with women of specific ethnic communities; training for WIC certifiers, nutritionists and clerks; providing information and materials to other states and organizations; and making presentations at national, regional and statewide conferences.

Learning from encounters

The cross-cultural encounters of staff, both within CFH and externally, are opportunities to apply cultural skills, and to validate or modify existing cultural knowledge. Cultural encounters with clients are also a culturally relevant base for developing culture-specific, individualized interventions.

IV.

FOUNDATION

Systemic Changes

Cultural competence is possible only when built into the very foundation of the organization.

Gradually, cultural competence is becoming part of the systems themselves, including the federal and state government systems, and DOH and CFH systems.

On the national level

On the national level, reports and funding sources increasingly emphasize cultural competence:

- The *Healthy People 2000 National Health Promotion and Disease Prevention Objectives* report emphasizes cultural competence as an important component in the development and delivery of health and nutrition services.
- The Preventative Health and Health Services Block Grant requires that *Healthy People 2000* objectives be met.
- The Title V and the Title X Maternal Child Health Block Grants emphasize culturally competent services.
- The Centers for Disease Control Breast and Cervical Health program focuses on elderly, low income, ethnic minority women.
- The Centers for Disease Control Diabetes Control program targets efforts around dietary changes within the Hispanic population.
- The American Stop Smoking Intervention Study includes ethnically diverse populations within its target populations.
- The Centers for Disease Control and Prevention target Asian and Pacific Islander ethnic groups due to their high rates of hepatitis B virus (HBV).
- Vaccines for Children provides free HBV vaccine for children of first generation immigrant women.
- Office of Sexually Transmitted Diseases (STD) Services provides funding to People of Color Against AIDS Network for outreach workers. STD educational materials are distributed in Spanish to local health jurisdictions, private clinics, hospitals, other health care providers and the general public.
- Title XIX has culturally specific grants and waivers that target underserved groups within Washington State.
- To assist states in meeting the federal mandates, the National Office of Maternal and Child Health established the National Maternal and Child Health Resource Center on Cultural Competency. Its mission is "to improve the quality of care and effectiveness of leadership in state Children with Special Health Care Needs agencies by creating culturally competent systems of care through policies, decision-making, staff training and service delivery."

On the state level

Washington State is moving forward in its commitment to diversity, equity and cultural competence. *Executive Order 93-07* from Governor Mike Lowry, September 27, 1993, affirms commitment to diversity and equity in service delivery and in the communities of the state. The Governor's Diversity Task Force collaborated with the public and private sectors to help state

agencies and higher education institutions meet the challenges of the order and of the *Governor's Diversity Initiative.*

In the Department of Health

DOH's systemic changes toward competence include reinstating the Office of Minority Affairs, creating the Secretary's Diversity Work Group, and emphasizing community partnerships.

Office of Minority Affairs. DOH reinstated the Office of Minority Affairs in 1992 as a result of a recommendation and action plan developed by the DOH Minority Affairs Work Group. Two members of this group were also members of the CFH Multicultural Work Group.

The Minority Affairs Work Group found that while DOH staff had a strong commitment to equity and diversity in the workforce, client base and contracted services, they needed assistance to expand their vision and efforts. As a result, the group recommended recreating the Office of Minority Affairs directly under the Secretary.

Goals: The office promotes cultural competence, and assures that services are accessible and responsive to the needs of ethnic minorities across the state.[2] The DOH management team expanded the goals to include respect for sexual preference, handicapping conditions and cultural concerns as well as ethnic differences.

Major activities:

- Public liaison with diverse communities and organizations;
- Consultation to executive and managerial staff in the development of policies and programs that are culturally appropriate, responsive and sensitive;
- Policy analysis and advocacy;
- Consultation on the development of a diverse workforce;
- Training and technical assistance;
- Capacity building and catalytic projects.

Accomplishments:

- The Office of Minority Affairs facilitated the Tribal Leaders Health Summit in 1994 in Seattle. As a result, a tribal work group formed to provide advocacy, policy review, analysis and recommendations on federal and state health reform activities affecting Native Americans.
- Collaboration of the DOH Office of Minority Affairs and other state agencies resulted in the Governor's proclamation of October 1994 as Minority Health Month.
- The office director served the Governor's Office and the Health Services Commission in an advisory capacity on the Seasonal Worker Work Group, contributing to the analysis and recommendations regarding health insurance for seasonal employees.
- Within DOH, the office has assisted with a community forum for the Maternal and Child Health (MCH) review process, Environmental Health's Asian Pacific Islander Outreach Project, and a work plan for temporary worker housing issues.

Secretary's Diversity Work Group. At the recommendation of the Minority Affairs Work Group, Secretary Bruce Miyahara appointed a Secretary's Diversity Work Group in early 1994. Chairing the new work group is the director of the Office of Minority Affairs. Three members of the CFH Multicultural Work Group are also members of the Secretary's group.

Goal: To challenge staff to change the culture of the agency to value diversity, and to institutionalize diversity in the department agenda.

Major activities:

- Examine and make recommendations concerning DOH policies and procedures on:
  - Mediation and resolution of employee grievances;
  - Limited English proficiency, interpreters and translators; and
  - Personnel recruitment and selection.
- Submit a DOH Diversity Plan to the Governor's Office in response to *the Governor's Diversity Initiative.*
- Explore the possibility of conducting a survey to assess where DOH stands concerning diversity and competence.

[2] "Minority Affairs Work Group Findings and Recommendations," Washington State Department of Health, July 24, 1992

Community partnerships. An example of DOH's trend toward building community partnerships is the *Public Health Improvement Plan*[1].

The *Public Health Improvement Plan* charts the future of public health in Washington. It describes how the public health system partners will meet the public health needs of communities. The needs identified are under the core functions of assessment, policy development, access and quality assurance, prevention and administration. The involvement of DOH staff and diverse communities from around the state assured an emphasis on culturally competent services in the plan.

For example, the plan requires each local public health jurisdiction to: "Identify barriers in a community related to transportation, language, culture, age, disability, education, information, and service delivery systems design that affect access to health services, especially for low income and other special populations."

The plan also requires all public health jurisdictions, both state and local, to: "Assure the development and provision of culturally, linguistically and age appropriate health promotion programs for community health priorities, including interpretive services."

In Community and Family Health

As a result of management and staff's strong commitment to acquiring cultural competence, CFH continues to make systemic changes.

Recruiting a culturally diverse, qualified staff. The Multicultural Work Group developed a recruitment plan to increase staff diversity within CFH. A diversity recruitment mailing list enables managers to choose from a more diverse pool of qualified applicants. The work group also provided the DOH Personnel Office with information on diversity recruitment and cultural competence training.

Comprehensive health data collection for minority-ethnic populations. As a result of the work group's efforts, beginning in 1992, the consolidated contracts for all CFH programs include racial and ethnic service reporting requirements.

Increased participation in funding and contracting mechanisms. CFH staff have a commitment to increasing the involvement of local health providers and community members in the planning and review of grant processes. Models include:

- Since 1995, new MCH grant proposals include a cultural competence checklist for applicants *(Appendix 5)*.
- Guidelines developed for quality assurance purposes also reflect issues related to cultural competence. (Beginning in 1996, new WIC contracts will specify cultural competence activities that WIC will monitor annually.)
- MCH representation in the Multicultural Work Group provides input and guidance for the MCH Block Grant.
- WIC policy on caseload management includes the provision of services to ethnically diverse and rural versus urban needs, and services to migrant, refugee and homeless populations.
- The Heart Health Program, funded by the Preventive Health and Health Services Block Grant, contracts with local communities to develop and implement community-based heart disease and stroke prevention services.
- The HIV Community Planning Process requires input from local health jurisdictions for program goals.

Service delivery and cultural competence. Several projects demonstrate CFH's increased competence in serving clients, including:

- CFH staff provide technical assistance to tribes throughout the state in establishing maternity support services. This includes technical assistance and training to women who serve on the maternity support services team. To improve coordination, communication and collaboration, CFH conducted a survey that addressed maternal and child health needs, concerns and priorities of each Native American community.

[1] *Public Health Improvement Plan*, Washington State Department of Health, Oct. 1994

- CFH staff are developing a plan to research eating and shopping patterns of ethnic and cultural minorities.
- CFH staff contributed a cultural diversity chapter to the first book on family centered care.
- The WIC State Plan includes the need for culturally competent services.
- The WIC program provides the AT&T Language Line for WIC agencies that lack interpreters.
- Heart Health Program and Breast and Cervical Cancer Project staff offer technical assistance to local agencies in providing outreach services to minority and other underserved populations.
- Multicultural Work Group members assisted the Association of State and Territorial Health Officials in developing their report, *Multicultural Maternal and Child Health Outreach: Case Study of Washington State Strategies to Assure Access for Asian and Pacific Islander Communities.*

Health promotion and cultural competence. As a result of CFH's increased cultural competence, several efforts are underway to increase the clarity of health promotion materials for specific populations. Examples include:

- CFH created a Low-Literacy Materials Development Task Force. Staff attended a workshop on writing for low literacy populations, and are developing low literacy versions of materials.
- CFH has new education materials translated into a minimum of one language other than English.
- Heart Health Program and Breast and Cervical Cancer Project staff have developed low literacy materials for client recruitment and education, and have had them translated and culturally validated for several cultures.
- The MCH/WIC outreach campaign targets special populations including ethnic minority groups, the homeless, low-literate women and the working poor.
- The MCH/WIC media campaign continues to fund the bi-lingual (Spanish) telephone operator and the AT&T Language Line.
- Staff is working with the Governor's four ethnic commissions to disseminate information about infant mortality and the importance of early prenatal care.
- CFH developed a substance abuse video and study guide specifically for African-American and Native American adolescents, and markets them to schools and local community health agencies.
- WIC staff are adapting the U.S. Food Guide Pyramid and dietary information to meet the dietary beliefs and practices of specific cultural groups, including Native Americans, Hispanics, East Africans, Southeast Asians and Eastern Europeans.

V.

STRUCTURE

The Working Plan

Like a blueprint, the strategic plan for competence must have the flexibility to meet changing needs.

More than four years of dedication by CFH management, the Multicultural Work Group and staff have increased the level of cultural competence, yet much work remains. A major task ahead is developing a strategic plan for acquiring cultural competence.

The National Maternal and Child Health Resource Center on Cultural Competency is funding training for 20 CFH staff on developing the plan and marketing it to CFH management, CFH staff and DOH administration. CFH will build the plan around the goals developed through the Cultural Awareness Training and Assessment process.

To identify those goals, the Multicultural Work Group studied all the feedback and evaluations of the workshop, developed goal statements, and distributed them to all staff for comment. A strongly committed staff provided thoughtful and extensive feedback on the goal statements. The work group revised the goals based on the responses, and presented them to CFH management for discussion and review.

The Multicultural Work Group expects broad participation and support from CFH and DOH in meeting these goals. Work group members also anticipate consulting with other DOH divisions as they establish their own work groups and work plans for achieving greater cultural competence.

Community and Family Health Cultural Competence Goals

Goal 1: Promote positive attitudes within CFH by recognizing the dynamics of difference among staff and clients, and understanding the value and importance of each of us.

Goal 2: Recognize the existence of prejudices within CFH, for example: homophobia, racism and sexism. Also recognize discriminatory attitudes directed toward persons with disabilities and persons based on age, job class or economic class. Take steps to reduce the effect of these prejudices and attitudes in the work place and for service delivery.

Goal 3: Increase meaningful client participation in program planning and evaluation.

Goal 4: Work in partnership with local contract agencies to enhance their cultural competence. In turn, provide more interchange between CFH programs and local agencies to share knowledge.

Goal 5: Foster individual office responsibility for promotion of cultural competence.

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VII.

APPENDICES

1. Cultural Competence Definitions
2. CFH Multicultural Work Group Mission
3. Preliminary Program Assessment
4. Selecting a Cultural Training and Assessment Consultant
5. Cultural Competence Checklist Accompanying Grant Proposals

Appendix I

Cultural Competence Definitions

Defining cultural competence

The Multicultural Work Group found the origins of cultural competence in "appropriateness of care," a primary goal of the National Institute of Mental Health, Child and Adolescent Service System Program (CASSP). CASSP seeks to assure that system service development takes place in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups.[4]

In choosing definitions concerning cultural competence, the work group chose to adopt those developed by the National Maternal and Child Health Resource Center on Cultural Competency. Cultural competence is a set of behaviors, attitudes and policies of a system, agency or individual that enables that system, agency or individual to function effectively in trans-cultural interactions. Cultural competence refers to a person or program's ability to honor and respect the cultural differences (beliefs, interpersonal styles, attitudes and behaviors) of individuals and families who are clients, staff administering programs, and staff providing services at state and local levels. In doing so, it incorporates these values at the levels of policy, administration and practice.

The word cultural is used because it implies an integrated pattern of human behavior that includes thought, communications, action, customs, beliefs, values and institutions of a racial, religious, socioeconomic, educational, occupational or geographical group. Cultural membership can also be identified by ethnicity, national origin, gender, hobbies, health status, age, sexual orientation, religion or political affiliation. The word competence is used because it implies having the ability to function effectively. Cultural competence is a goal that a system, agency or individual continually aspires to achieve.[5]

A culturally competent system recognizes that: (1) Families are the primary system of support and the preferred point of intervention. (2) Individuals and families make different choices based on cultural forces. (3) Cultural minorities have to be at least bicultural to survive in our society, and this creates a unique set of stresses. The system must incorporate this cultural knowledge into practices and policies, and facilitate community control over service delivery. This requires commitment at every level of the system: policy makers, managers, practitioners and consumers.

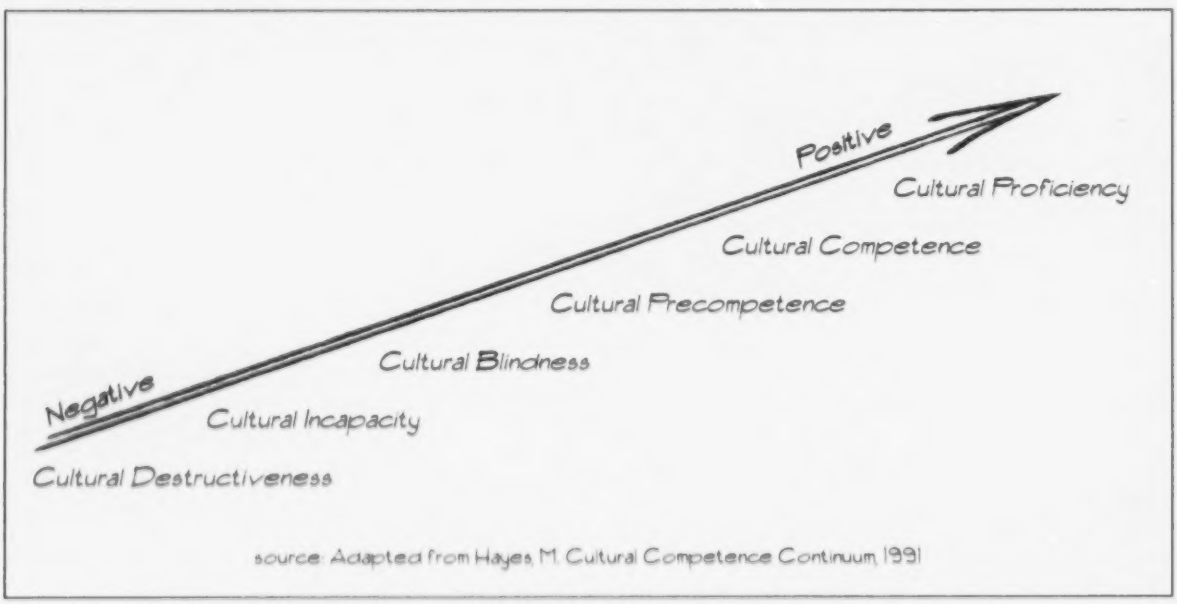
[4] *Towards A Culturally Competent System of Care*, Vol. I, CASSP Technical Assistance Center, Georgetown University Child Development Center, March 1989

[5] Definition developed by the National Maternal and Child Health National Resource Center on Cultural Competency

The cultural competence continuum

The cultural competence continuum (see illustration below) defines the stages of proficiency for individuals and agencies in their efforts to acquire the various aspects of competence. Although the illustration of the continuum appears linear, one's movement toward proficiency is non-linear. Movement on the continuum is like the movement of particles in an atom. Each individual travels at a different speed and on a different path, making progress, facing setbacks and continuing forward. The competence achieved in aspects of culture or cultural groups can differ greatly within the same individual. For example, a person could acquire a high level of competence in serving specific ethnic groups, while being precompetent with gay and lesbian issues.

Cultural Competence Continuum

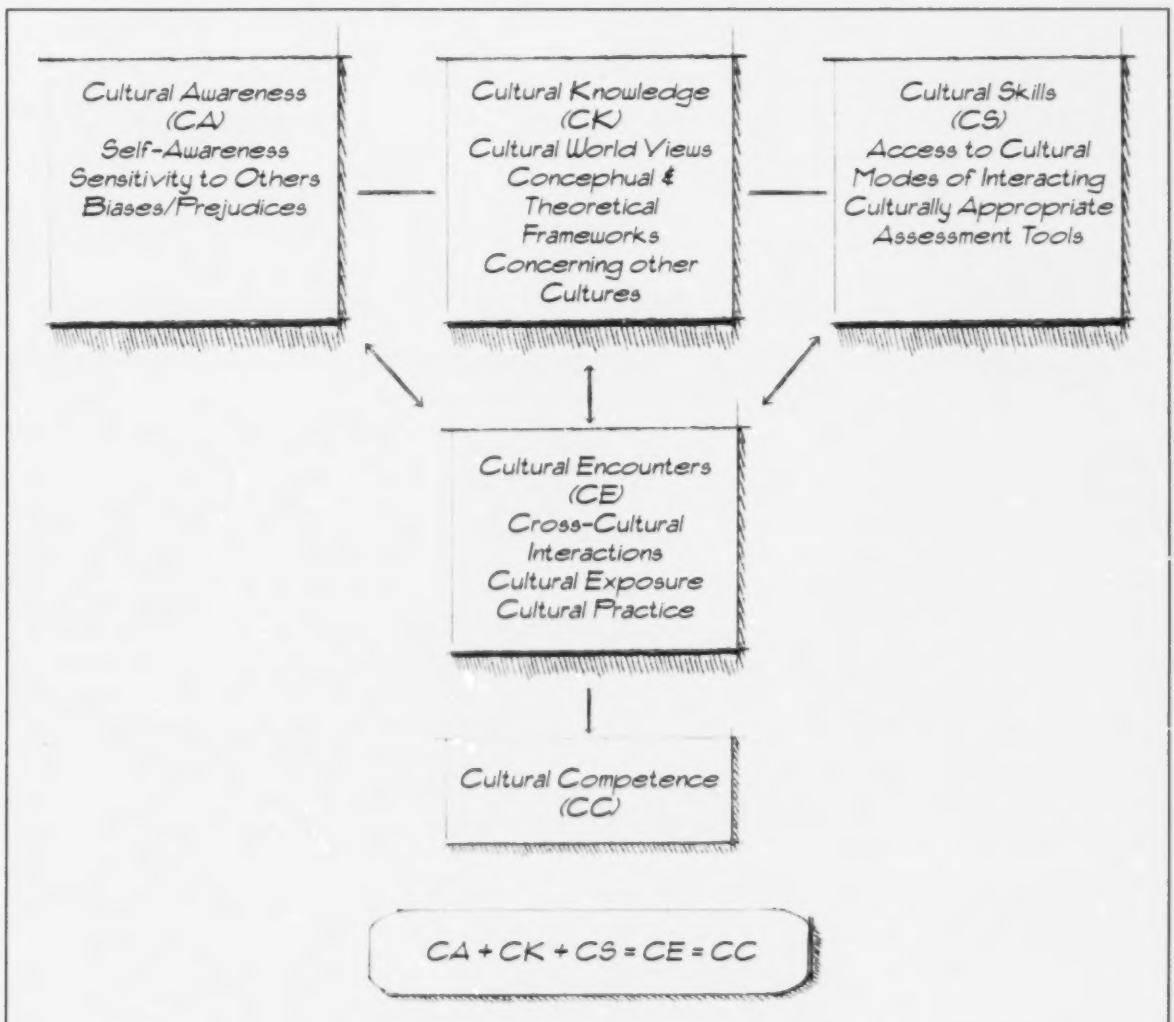


source: Adapted from Hayes, M. Cultural Competence Continuum, 1991

A culturally competent model of care

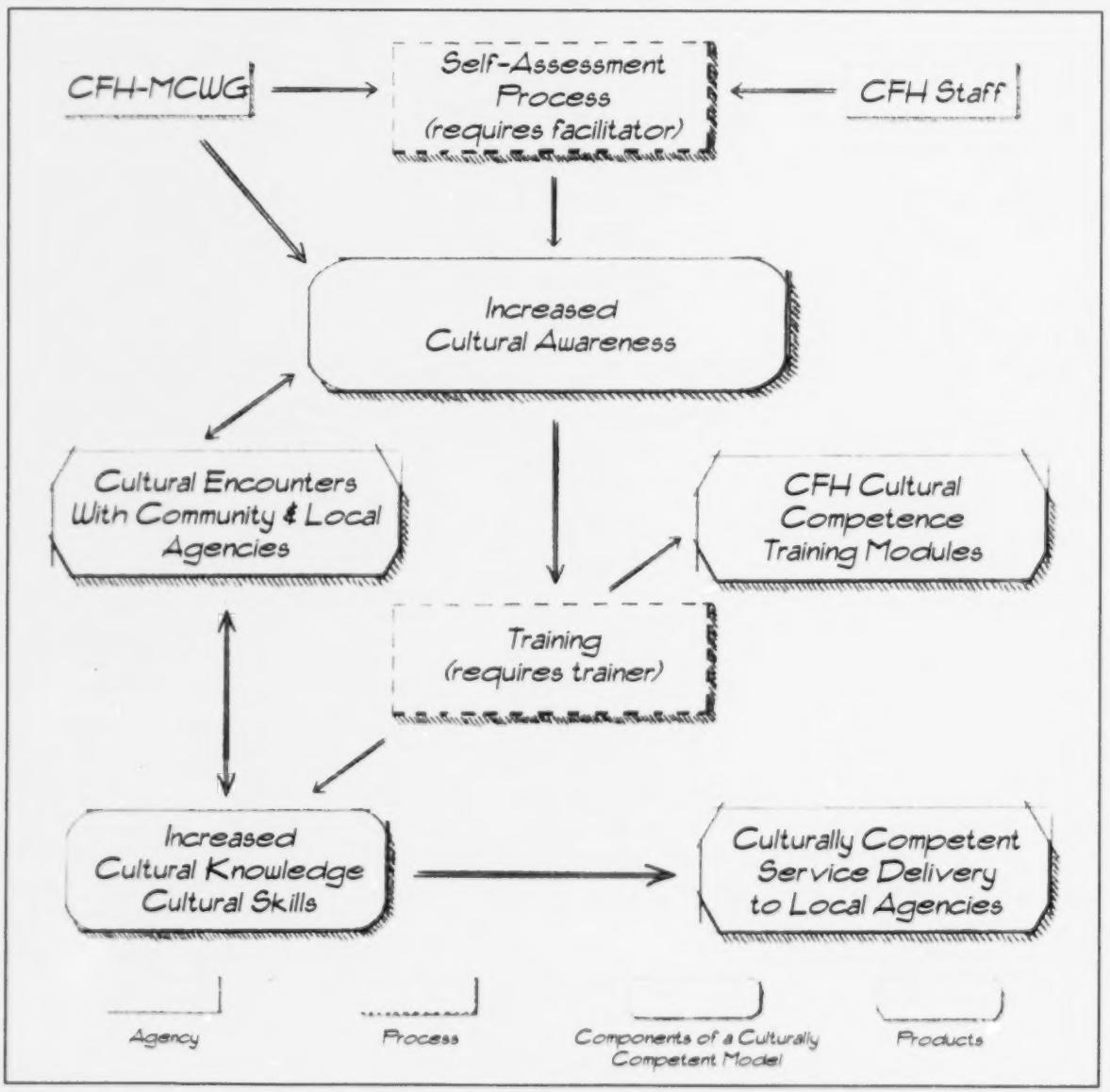
Acquiring cultural competence is a developmental process. Individuals acquire cultural awareness, knowledge and skills through training, books and other didactic processes, but most importantly through encounters with culturally diverse individuals. As awareness, knowledge and skills increase, further encounters with clients from diverse cultural groups become enriching and sensitive experiences. These experiences promote better understanding of community needs and improved access of services. This process does not occur in any specific linear manner. Individuals can acquire different aspects of competence at different times and through a variety of means.

A Culturally Competent Model of Care



Source: adapted from "The Process of Cultural Competence" by Josepha Campinha - Bacote, Transcultural C.A.R.E. Associates, 1991.

CFH Framework for Acquiring Cultural Competence



Appendix 2

Community and Family Health Multicultural Work Group Mission

To promote a respectful and inclusive atmosphere where all employees are encouraged to do effective work in assuring optimal health for communities, families and individuals in the state of Washington.

This two-fold aspect of the work group's mission is achieved through the following steps:

- Promote a respectful and inclusive work atmosphere by:
  - Developing an awareness and understanding of individual differences among employees;
  - Developing an appreciation of these differences; and
  - Developing acceptance and respect among employees as we work together to achieve our goals.
- Assure optimal health for communities, families and individuals by:
  - Promoting an atmosphere within the organization that encourages employees to recognize the individual differences and needs of all its clients;
  - Meeting the health needs of clients with different health beliefs and norms; and
  - Creating a system that allows for creative and flexible solutions to meet these health needs.

Appendix 3

Preliminary Program Assessment

The following questions will help you assess your program's strengths and accomplishments as well as weaknesses in cultural competence:

1. Which trainings have you attended that specifically addressed areas of cultural competence?
2. What specific training or consultation have you provided to local agencies in the area of cultural competence?
3. What projects or program components do you fund or monitor that address the needs of various cultural and ethnic groups?
4. Are the client and patient education materials available in languages and reading levels appropriate for the population you are serving? Are they culturally appropriate?
5. Does your staff include members of diverse cultural and social groups?

Appendix 4

Selecting a Cultural Training and Assessment Consultant

Cultural consultant guidelines

In evaluating applicants, the work group followed the guidelines in *The Ideal Cultural Consultant*, Northwest Indian Child Welfare Association:

- community recognition
- community involvement
- advanced identity development
- sub-group diversity awareness and sensitivity
- articulate in at least two world views
  - cultural knowledge
  - physical and material traits of culture past and present
  - dynamic and abstract traits of the culture and current structures, practices and players
  - unique mental health issues, healing practices, world view
- knowledgeable and able to manage dynamics of difference

Agency considerations

The work group also weighed agency considerations such as:

- consultant fees
- availability not only for the initial training but on an ongoing basis
- agency needs and whether the consultants could fulfill the needs
- flexibility; adaptability to agency needs
- ability to accept input
- listening capabilities to find out agency needs
- consultant's focus and experience
- references
- consistency of their definition of cultural competence with agency's definition
- compatibility of personalities

Interview questions

Work group members asked the following questions during the interview process:

1. How did you become involved in this work? (Question targets world view and community involvement.)
2. What experience have you had working with agencies in becoming culturally competent?
3. How does our definition of cultural competency fit with your focus, the process you use, and materials and tools you have developed?
4. Tell us what you feel individuals and agencies need to do in terms of looking at our attitudes, beliefs and behaviors.
5. What process would you use to assist staff in our agency to complete a self-assessment and plan for future training? Are there any specific tools you would use or develop?
6. What outcomes do you expect from the self-assessment process?
7. In your experience, what have you found agencies such as ours need to do after the self-assessment to move toward competence?
8. How would you deal with conflict and disagreement in groups?
9. Are you available to complete the self-assessment by _____(date)_____?
10. Are you available to work with us on an ongoing basis as we move past the self-assessment process?
11. What other organizations have done similar consultation with you? (References)

Contract deliverables

As a result of the process, the work group selected Daniel Duarte and John Lenssen of Duarte & Associates of Tualatin, Oregon, to facilitate the workshops. The initial contract required:

- Eight hours of consultation with the work group to design and prepare for the workshops, and to train work group members as facilitators;
- Eight-hour assessment workshops; and
- Eight hours with work group members to evaluate workshops, compile results, recommend next steps, and prepare documentation for the National Maternal and Child Health Resource Center on Cultural Competency.

When two divisions merged as the Community and Family Health Division, DOH contracted for additional assessment workshops and consultations to assure that all staff received a similar training and experience.

Appendix 5

Cultural Competence Checklist Accompanying Grant Proposals

Service Delivery Assessment[6]

Please mark the appropriate box that best represents your organization's service delivery.

	Yes	No
1. Do you provide interpreter services for your clients?	❑	❑
2. Do you provide culturally specific, translated materials for your clients?	❑	❑
3. Do you provide special outreach programs for cultural groups?	❑	❑
4. Do you provide any type of transportation for your clients?	❑	❑
5. Do you provide access, other than regular 8 to 5 working hours?	❑	❑
6. Do you market health prevention messages to cultural groups?	❑	❑
7. Are people from cultural groups depicted in posters and brochures?	❑	❑
8. Have staff members been trained to work with the same cultural group they serve?	❑	❑
9. Does staff have close ties with the community they serve?	❑	❑
10. What percent of staff live in the community where services are provided?____		
11. Does staff know the culture and health status of the cultural groups they serve?	❑	❑
12. Is staff accepted by the cultural groups they serve?	❑	❑
13. Is there in-service training on cultural diversity for staff?	❑	❑
14. Is there in-service training on cultural health barriers for staff?	❑	❑
15. Has staff been trained to work cross-culturally?	❑	❑
16. Are culturally aware staff members placed in agency points of entry?	❑	❑
17. Do you accept and make referrals to and from cultural specific alternatives?	❑	❑
18. Do you use culture specific assessment tools for diagnosis and treatment?	❑	❑
19. Do service/management plans integrate the individual's traditional beliefs and practices?	❑	❑
20. Do you use culture specific treatment approaches?	❑	❑

[6] Developed by the National Maternal and Child Health Resource Center on Cultural Competency. Revisions made by Washington State Department of Health. 6/95.

The National
Maternal & Child Health
Resource Center on
Cultural Competency